DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Refer to: WDSC-RA

May 10, 2016

Administrator
Los Angeles Community Hospital
4081 E Olympic Blvd
Los Angeles, CA 90023

Re: Medicare Provider Number 050663
Restore Deemed Status

Dear Administrator:

The Centers for Medicare & Medicaid Services (CMS) has determined that Los Angeles Community Hospital now meets the Medicare Conditions of Participation (COPs) for a provider of hospital services and therefore, this office will not proceed with a termination action. The authority for this decision is found at 42 C.F.R. § 498.20-498.25.

The April 27, 2016 survey completed by the California Department of Public Health determined that the hospital has demonstrated compliance with the Medicare Conditions of Participation.

Therefore, effective the date of this letter, we are removing your facility from the CDPH survey jurisdiction and restoring your facility's deemed status, based on your continued accreditation by The Joint Commission (TJC). The enclosed Statement of Deficiencies (CMS-2567) documents the findings of the April 27, 2016 survey.

We have forwarded a copy of this letter and the findings from this survey to the TJC for its review. Copies of this letter are being sent to the CDPH and the State Medicaid agency.

If you have any questions about this matter, please contact Rosanna Angeldones at 415-744-3735.

Sincerely,

Rufus Arther, Manager
Non Long Term Care Branch

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050663	A. BUILDING _____ B. WING _____	R-C 04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOS ANGELES COMMUNITY HOSPITAL	4081 E OLYMPIC BLVD LOS ANGELES, CA 90023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Second Revisit Complaint Validation survey. Complaint Number: 462024 Representing the Department: 27137, HFEN 36543, HFEN The census was 112 and the sample size was 30. The hospital is in substantial compliance with the regulations during this revisit. Conditions met.	{A 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.